Initial Approval: July 13, 2016
Revised Dates: January 11, 2017

CRITERIA FOR PRIOR AUTHORIZATION

Non-Preferred Metformin ER Step Therapy

PROVIDER GROUP Pharmacy

MANUAL GUIDELINES The following drug requires prior authorization:
Metformin ER (Fortamet®, Glumetza®)

CRITERIA FOR PRIOR AUTHORIZATION APPROVAL (must meet all of the following):

- Patient must have a diagnosis of type 2 diabetes mellitus (noninsulin dependent)
- Patient must have a prior therapy with generic metformin IR (unless patient initiated on extended-release formulation)
- Patient must have a prior therapy with generic metformin ER (Glucophage XR® equivalent) for at least 90 consecutive days of therapy in the past 120 day period

LENGTH OF APPROVAL: 12 months

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DRUG UTILIZATION REVIEW COMMITTEE CHAIR	PHARMACY PROGRAM MANAGER DIVISION OF HEALTH CARE FINANCE KANSAS DEPARTMENT OF HEALTH AND ENVIRONMENT
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DATE	DATE